Rural Medical Care and Hospitalization

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THE provision of adequate medical care for rural populations is, and has been, one of the most sluggish and least popular branches of the broad field of modern medical development. This is due largely to lack of concentrated capital and personnel requisite for proper organization of the necessary facilities.

The rural practitioner has been handicapped by numerous factors. First, doctors are burdened with excessive case loads and long traveling distances. Second, excessive costs of laboratory equipment, hospital facilities and salaries makes individual operation or ownership difficult or impossible. Third, competitive and proprietary institutions with inadequate facilities have, by and large, defeated the purpose of expansion and modernization comparable with advances in the medical field generally. Fourth, public interest and individual initiative so necessary to continued progress in any project are, in the country, more inert to progressive changes and more subject to stifling provincialism.

Little wonder that the country doctor and his practice is the frequent subject of jests as a relic of the past. Be that as it may, the epitaph of "Dr. John Goodfellow, Office Upstairs" still remains solid in the hearts of his appreciative clientele. He still is the barrier between them and fear of illness and death. His failures too often result from circumstances largely beyond his individual control.

The speed and precision of modern life is now incompatible with the present state of rural medical practice. Farm life and industry are mechanized and the rural populace is as intellectually advanced as its city cousins. Neither the younger generation now returned from military service, nor the older adults who are well read and alert to modern trends in all phases of living, will be content for long with inferior medical care or slow in discerning inadequacies. Rh factor, antitoxin, biopsy, penicillin, streptomycin and many modern terms have supplanted the antique "germ," "microbe," "drugs," "dope" and "pills," for the most part.

With nearly 14 years of practice in a small agricultural valley, fortunately located within 45 miles of San Francisco, but so peculiarly isolated geographically as to remain definitely rustic, the writer is prompted to articulate some of the particular and peculiar problems, together with suggestions for their ultimate solution.

THE DOCTOR—POSTGRADUATE AND CONTINUATION TRAINING

Individual rural practice almost invariably prevents any but brief, cursory and superficial pursuit of postgraduate training without the disruption of the continuity of care of individual patients and practice in general. Extended postgraduate study usually results in the physician or surgeon leaving the community for wider fields with greater facilities. The average country practitioner usually begins practice with from one to perhaps three years of hospital training as a background for practice. It is the exceptional physician indeed who could not profit greatly by periodic six to twelve-week practical courses in one or several branches of medicine at one to three year intervals. Such courses should be readily available at not too great a cost in time, money and sacrifice to himself and his family.

There is little basis for argument as to the value of short courses presenting practical and theoretical material to the individuals of more or less limited training and experience in any field. The problem is to provide this training simply, efficiently and economically. With all due regard to the faculties and organizations providing the present postgraduate courses, they leave much to be desired. Week-long refresher courses are necessarily limited to a few hundred applicants. The limited enrollment of the "once a week" courses held in a central metropolitan area is limited to a relatively narrow zone and number of individuals. The "team-clinics" sent out to the hinterland can only present a very brief and limited course with very slight opportunity for practical participation by the recipient. In short, present facilities are mere tokens of the desirable manna.

A plan designed to fit many of the requirements for postgraduate training for the physician in general practice can be outlined as in the accompanying chart. The scope and ramifications are at once apparent. The financial involvement seems insurmountable. The procurement of hospital and teaching facilities, the development of a teaching staff and the clerical assistants, the integration of the program with existing medical school training, are all promethian tasks. The answer lies not only in the response or demand of the doctor in general practice but in the voice of the entire medical profession in answer to the query, "Is it worth it?"

If the present hue and cry for improvement of the profession and particularly the status of the "general practitioners" is anything but lip service, the answer is definitely in the affirmative.

No comprehensive postgraduate schools open to men in general practice exist west of the Mississippi. Is this not another challenge to California Medicine? If the recent premise is true that general practice is a separate entity or "specialty" should we not have facilities for training the recent graduate beyond those presently available?

The rural communities need certified men but this may not be immediately feasible or practical, nor is it particularly economic for the more isolated regions. The writer should rather suggest the team principle, with each practitioner developing his own

particular aptitudes and preferences, supplemented by periods of postgraduate training and integrated with those of his fellows in meeting the needs of the community, assisted by a well organized consultative service recruited from the more populated adjacent cities. This is by no means a new idea but the development of the program is still largely a matter of chance selection rather than purposeful design. Petty personal and professional jealousies and false concepts and interpretation of medical ethics have too often defeated this type of development.

COMBINED OFFICE FACILITIES

The presence of two or more individual office units is as uneconomical as it is inefficient. The duplication of expensive x-ray, laboratory and therapy equipment needs no further condemnation. Pooling of facilities, cooperative use of personnel and equipment in carefully designed quarters provides for more efficient use of a wider variety of technical and special services. The elimination of one or more unskilled employees would provide a salary for a trained laboratory technician. The personnel for rural practices must necessarily be diversified in their abilities and training and not necessarily too highly specialized. There is not place (nor enough work in the average rural doctor's office) for a trained laboratory technologist. As a result, one of the personnel is impressed into doing routine urines and blood counts in an indifferent fashion with an unknown percentage of error, or the doctor wastes his valuable time or holds the laboratory work at an irreducible minimum and so neglects this important factor in diagnosis. Improvement lies in the direction of mutual assistance and cooperation in the profession.

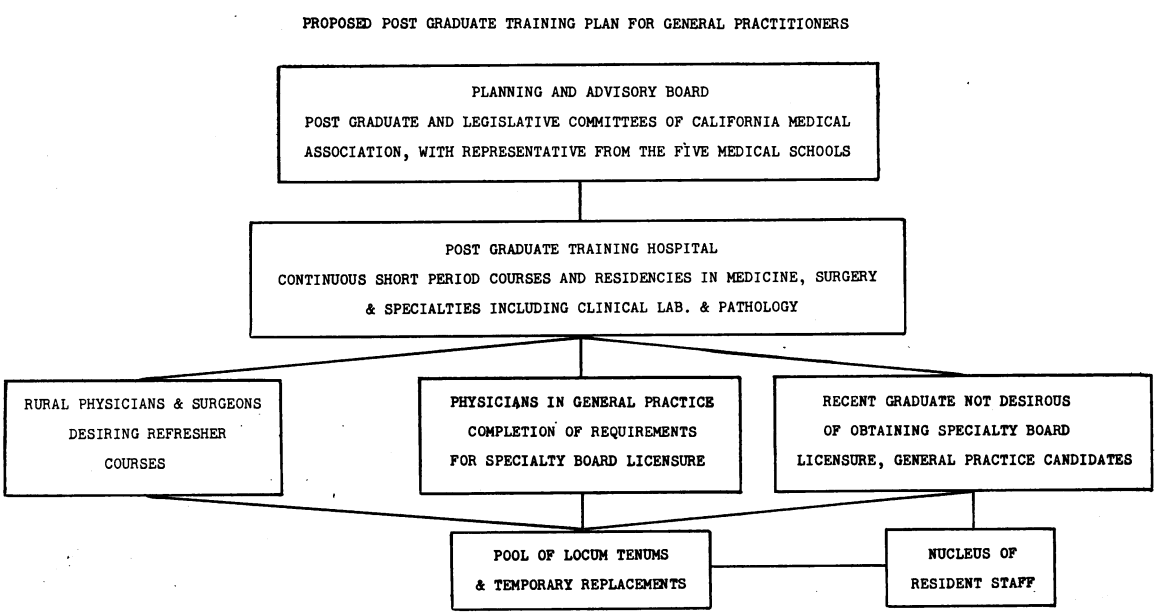
THE HOSPITAL

The universal plea of rural physicians and patients alike is for more adequate hospitalization. The immediate thought is for the prompt care of the present sick individual. The underlying and often neglected principal benefit of the hospital to physician, patient and community is in *improved* medical care and service. The personal experience of this writer in hospital organization and development is illustrative of this point.

The only hospital available to the Sonoma populace was a proprietary sanitarium operated by an elderly practical nurse from 1922 to 1939. The bed capacity increased gradually, through additions, from one bed to eventually ten beds with four nursery cribs. One room served as surgery and delivery room combined. The equipment and furnishings were superannuated. There were no laboratory facilities. In 1941 a modern delivery table was installed by the writer. A very antique portable x-ray was installed in 1939. It was replaced in 1942 by a modern mobile unit. Management from 1939 to 1944 was by a layman with no previous hospital administrative experience. From 1944-1945 for a period of nine months the sanitarium was operated as a non-profit partnership by the three practicing physicians in the community with a full time business manager.

During the years 1942 and 1943 an application under the Lanham Act failed to obtain funds to purchase and equip an existing state-owned hospital building in the community which was to be disposed of as a result of wartime economies of personnel and materiel. In August of 1944, the poor health of the lay owner and manager of the very inadequate and out-of-the-way sanitarium necessitated the formation of a non-profit partnership of the three practicing physicians of the community to take over its operation, in order to maintain service for medical, obstetrical and minor surgical cases.

Early in 1944 general meetings in the community were begun by securing the general support of the civic and community organizations. This resulted in



the formation of a hospital committee under the chairmanship of the writer and included representatives from every part of the community, with all the doctors acting in an advisory capacity. This movement resulted in the formation of a non-profit organization, the Sonoma Valley Community Hospital, which was incorporated through the offices of a local attorney.

A tentative budget was set up for the rehabilitation and operation of the previously mentioned state-owned hospital building. This budget included rental of the building on a long term lease from the private individual who had meanwhile acquired the building and surrounding property from the state.

A fund-raising campaign was undertaken by the committee under the chairmanship of the local high school principal, on the stipulation that the Board of Trustees undertake the long range program of insuring the permanence and perpetuation of the hospital assets. This was proposed to be done through the formation of a district, similar to school, irrigation or other administrative district.

According to the plan of the Board of Trustees, the original budget estimate called for raising $25,000 which included a 15 per cent reserve contingency fund. The funds were raised by private subscription, a contribution of from $5 to $100 entitling the donor to one non-assessable voting membership in the non-profit corporation plus an additional voting membership for each additional $100 contributed. A total of $33,444 was raised, of which $5,135.95 was spent on alteration, $15,405.93 for equipment and $3,298.44 for supplies, leaving $9,603.88 unexpended.

Our local attorney, together with a subcommittee and with the assistance of Senator Herbert W. Slater of Santa Rosa, prepared a provisional bill with the assistance of the Legislative Advisory Committee in Sacramento on November 9, 1944. The proposed bill was submitted to and discussed with the chairman of the Legislative Committee of the California Medical Association, Dr. Dwight H. Murray, and legal counsel of the California Medical Association, Mr. Hartley Peart and Mr. Howard Hassard, for suggestions and criticisms. In January of 1945, Senate Bill 586 was introduced by Senator Slater, ultimately passed and signed by Governor Earl Warren on June 18, 1945. (A similar bill had been introduced into the same session of the Legislature by Senator Chris N. Jesperson but was withdrawn in favor of Senator Slater's bill.)

The bill provides for the formation of districts in a county or portion of a county or adjacent counties of a population of 200,000 or less, according to the usual form of procedure prescribed for this and similar districts. It requires that a petition, signed by 15 per cent of the registered voters of the district be presented to the County Board of Supervisors. Election is set and held in the district designated and the district is formed if a majority of the vote be in favor. A resolution, so stipulating, is filed with the Secretary of State in Sacramento by the County Board of Supervisors.

Annexation of land is provided for by the same procedure. The five members of the Board of Directors, residents and regular voters, hold office for a term of four years. The first board is appointed by the county board of supervisors and members are replaced or reelected in the next two general elections. The duties and powers are prescribed as to execution, administration and management of the hospital. Rules and regulations are set up and rates established to permit operation of the hospital on a self supporting basis.

The fiscal provisions of the original bill were as follows:

1. Daily receipts paid into the treasury of the district in a special operation fund and used for payment of operating expenses, construction costs and interest on bonds, and to maintain a reserve fund;
2. A local hospital district fund is established in the county treasury;
3. An annual assessment based on the hospital budget submitted to the county board of supervisors together with a petition for tax levy not to exceed 20 cents per $100 valuation;
4. A capital outlay fund;
5. Special assessments;
6. Bonds.

On November 4, 1946, the California Supreme Court handed down a decision validating bonds issued by such districts, pursuant to the stipulations in the bill. On January 21, 1947, Senate Bill 227 was introduced by Senator Slater which clarified the financial provisions, provided for a bonded treasurer and validated actions taken by any districts prior to the passage of this amendment. This was passed by the senate and the assembly and subsequently signed by Governor Warren as an emergency measure effective immediately.

Assembly Bill 64 introduced by Mr. Dunn of Alameda County providing for an amendment to the Hospital District Law permitted districts to be formed in counties of populations up to 500,000, as compared with the previous 200,000 population limitation.

Twenty-four districts are now actually organized. A county-wide district was organized in Del Norte County and is in operation. This district, which has taken over the Knapp Memorial Hospital, provides care for indigents at county expense in addition to the private patients.

May 1, 1947, the Sonoma Valley Community Hospital Board of Trustees officially assigned its properties and assets to the Board of Directors of the Sonoma Valley Hospital District, which was formed as a result of an election held March 19, 1946. It thereby became the second hospital district in actual operation.

The Local Hospital District Law appears to be a definite advancement for rural medical care. It is locally controlled by individuals cognizant of their particular hospital problems. It is relatively devoid of political domination and pitfalls, unless subsequently altered, and it provides a simplified procedure for raising funds for initial construction.

equipment and maintenance through economic fluctuations so frequently disastrous to smaller private and proprietary institutions.

This bill, as an instrument of the medical profession and the people, requires the constant efforts of the local physicians and members of the medical staffs, as its efficiency and usefulness must necessarily depend upon the intelligent advice and supervision by the profession working cooperatively with the lay individuals and groups. Due to strict interpretation of the State Code relative to direct or indirect contract between a member of a state, county or municipal tax supported institution, the medical profession is barred from hospital district board membership, but its influence can be made effective through tactful assistance.

A great deal of assistance may be derived from advice and material from the State Department of Health, Bureau of Hospital Surveys, under the direction of Dr. P. K. Gilman and staff. This will be mainly in coordination, reduction of duplication and efficient overall planning.

As to the efficiency of small hospitals in providing hospital care, a summary of the last annual statement of our community non-profit hospital organization is as follows:

JANUARY 1 THROUGH DECEMBER 31, 1946

HOSPITAL OPERATIONS

Receipts		$74,108.81
Expenses	$27,444.91	
Salaries	30,730.39	58,175.30
Operating gain		$15,933.51

SERVICES RENDERED

Medical	404
Minor surgery	140
Major surgery	68
Orthopedic	26
Obstetrical	168
Caesarean	7
Newborn	175
Total admissions	995
Adult bed complement	22
Total in patients	760
Total patient days	5,985
Daily average patients	16 83
Average per cent occupancy	75.59%
Average patient stay	7.87
Newborn bed complement	4
Total newborn patients	175
Total newborn days	1,332
Daily average newborn	3.70
Average per cent occupancy	99.25%
Average newborn stay	7.61
Expired: Under 48 hours	8
Over 48 hours	18
Stillborn	1

The hospital is the central unit in the consummation of the program for rural medical care. As such it should function to consolidate the medical profession and the community as a whole into a unit for improving the general health. If these developments in rural medical care progress as rapidly as is indicated by the organization of the 24 hospital districts since Senate Bill 586 was enacted, a great increase in diversified local hospital personnel will be immediately needed. This personnel is now inadequately provided for in the curricula of any of our state, public or local schools, hospitals or institutions. It behooves the entire medical fraternity to take cognizance of this problem and institute immediate steps to implement this field of medical progress. Education of personnel of the district hospitals may be assisted through the services of itinerant supervisors in various branches of hospital operation.

The Sonoma Valley Community Hospital Board of Trustees was particularly fortunate in having available personnel from which to recruit a staff. Nevertheless, the ultimate organization and placement of the individuals was only possible through careful selection, advice and the board members' own personal study and desire to ensure proper and effective hospital operation. There have been and still are a multitude of problems requiring improvement if not correction. There is no "Blue Book" to guide the course. The speed of solution is directly proportional to the energy and diligence applied by the naturally constituted leaders, the medical profession.

SUMMARY

1. Personal observations of the requirements of present day rural medical practice based on the experience of the past 14 years' practice in Sonoma, California;

2. An argument presented for more frequent and comprehensive short periods of postgraduate training for the doctors, by means of providing a plan for continuous operation of a postgraduate hospital and service available to recent graduates as well as those already experienced in practice;

3. Modernization of office facilities and personnel for more efficient and accurate operation proposed;

4. Description of efforts and accomplishments in improved hospitalization through the development of the Local Hospital District Law and its application to an individual community;

5. Small hospitals can provide efficient, adequate and economical care and as such are the central units in solving the problem of Rural Medical Service;

6. Adequate overall progress requires the training of a large corps of new personnel not now provided for. This burden will necessarily fall upon the shoulders of organized medicine and its subsidiaries for planning, guidance and instruction.

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